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IN THE

Supreme Court of the United States

OCTOBER TERM, 1978

No. 78-711

SOUTHEASTERN COMMUNITY COLLEGE, *Petitioner,*

v.

FRANCES B. DAVIS, *Respondent.*

On Writ of Certiorari to the United States Court of Appeals for the Fourth Circuit

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BRIEF AMICUS CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

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OPINIONS BELOW

The opinion of the court of appeals is reported at 574 F.2d 1158 (4th Cir. 1978); the opinion of the district court is reported at 424 F. Supp. 1341 (E.D.N.C. 1976).

CONSENT TO FILE

This Amicus Curiae brief is being filed with the consent of all parties to the proceeding.[1]

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[1] Letters of consent of all parties to the case have been filed with the Clerk of the Court.

INTEREST OF AMICUS

The Association of American Medical Colleges is a voluntary, nonprofit, non-governmental corporation established under the laws of the State of Illinois, having its principal place of business in the District of Columbia. Its corporate purpose is the advancement of medical education. Its institutional membership includes all one hundred twenty four accredited and operating non-profit medical schools and medical colleges in the United States. Its membership also includes over 400 teaching hospitals in which undergraduate and graduate medical education is conducted, and 68 academic societies, the members of which are medical school faculty or otherwise actively engaged in medical education. *Amicus* fully supports equal rights for handicapped persons and the purpose of § 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Its members conduct programs and activities receiving Federal financial assistance and have an obligation to comply with the Act. They have a concomitant responsibility for the well being of patients, those directly entrusted to their care and those eventually seeking the assistance of the physicians they train. Because the Act as interpreted by the court of appeals threatens to undermine their ability to meet this latter obligation, *amicus* has an important stake in this Court's consideration of the case.

It is the firmly held belief of *amicus* and its members that the practice of medicine, regardless of the specialized branch ultimately pursued, requires the acquisition of a fundamental competence in biomedical and behavioral sciences, the development of basic clinical skills and the capability of exercising sound clinical judgment. It is toward these ends that undergraduate medical education leading to the M.D. degree is directed. All medical students are required to take not only didactic courses in theoretical science but also clinical clerkships involving the personal assumption of responsibility for the care of patients under supervision. This nexus between medical education and patient welfare, disregarded or inadequately considered by the court of appeals, constitutes the basis of *amicus'* concern. For it is a virtual certainty that certain handicaps will be so debilitating as to prevent a person from safely carrying out tasks and accepting responsibilities required of all students in the M.D. program. Persons with such handicaps would not only be incapable of successfully completing the program, they would be a hazard to the well being of the patients with whom they come in contact. It would be irresponsible and immoral for medical schools to accept such persons as medical students. It cannot have been the intent of Congress in enacting section 504 that medical schools be required to do so. Yet that appears to be the result which follows inescapably from the order of the court below that the candidate be evaluated for admission *without regard to her disability.*

QUESTIONS PRESENTED

I. Whether section 504 of the Rehabilitation Act of 1973 must be construed to require an institution of higher education receiving Federal funds to admit a handicapped person whose handicap makes it impossible to participate effectively in the educational program and the career to which it leads?

II. Whether section 504 requires an institution to change its academic requirements or take other action to compensate for the disability of a handicapped applicant for admission?

III. Whether section 504 impliedly creates a private right of action that may be enforced by an individual without resort to federal administrative remedies?

Of these the Association of American Medical Colleges will address only the first which bears directly on its particular interest as *amicus*.

ARGUMENT

The statute prohibits the exclusion of "an otherwise qualified handicapped individual . . . solely by reason of his handicap" from any program or activity receiving Federal financial assistance.[2] The key terms "otherwise qualified," left undefined by the Congress, were interpreted by the district court in a fashion described by the court of appeals as giving them "their ordinary common meaning."[3] Neither their ordinary meaning, nor the definitions in the subsequently published HEW regulations[4] require the result reached by the court of appeals, that the admission decision be made *without regard to* the handicap.[5]

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[2] Section 504 provides that:

> No otherwise qualified handicapped individual in the United States, as defined in section 706(6) of this title, shall, solely by reason of his handicap, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.

[3] 574 F.2d at 1160.

[4] 45 C.F.R. § 84.3(k)(3) requires that:

> With respect to post-secondary and vocational education services [an otherwise qualified handicapped person is one] . . . who meets the *academic* and *technical* standards requisite to admission or participation in the recipient's education program or activity. [Emphasis added.]

[5] 574 F.2d at 1160.

Arguably, the evil that Congress intended to remedy was the practice of arriving at unwarranted judgments to the detriment of handicapped individuals on a superficial observation of the handicap rather than a diligent inquiry into the capability of the person, with appropriate support, to perform satisfactorily the tasks legitimately required of all matriculants or participants. This view is consistent with the conclusion of the district court, it is reconcilable with the HEW implementing regulations, and it is consistent with the court of appeals' focus on academic and technical standards rather than on handicap. All that is necessary is the recognition that concepts which must now be articulated by academic institutions under the rubric of technical standards[6] have always played an important role in academic decisions.

Programs educating students for entry into the health professions have always included in their admissions deliberations considerations related to the suitability of the applicant to provide patient care. Indeed, the safety and welfare of patients is of primary concern, not only with respect to those patients that the student may ultimately encounter in his post-educational career, but also those who will receive his ministrations during the training period. Thus, any person who represents a potential hazard to patients because of his inability to satisfactorily perform required tasks, even though academically qualified, has never been regarded as an admissible candidate. While it is arguable that such performance requirements should have been

---

[6] "The term technical standards refers to all nonacademic admissions criteria that are essential to participation in the program in question." 45 C.F.R. § 84 App. A, at 376 (1977).

articulated in a far more explicit fashion in order to assure a fairer evaluation of all candidates, it is nevertheless true that prior to the publication of the HEW regulations, there had never been any *requirement* (nor from a school's point of view, any pressing need) to do so.

Thus, the district court decision, having been reached prior to the publication of the HEW regulations, related to legitimate and important academic concerns but focused inappropriately on the handicap rather than technical qualifications or the performance expectations. The appellate court's focus on academic and technical standards is well placed but its remedy was misdirected. Instead of requiring Southeastern to consider Davis without regard to her handicap, it should have required the institution to specify, and measure Davis against, supportable technical performance standards related to the legitimate demands of the program on all participants.

The discussion by the court of appeals of limited v. unlimited certification at footnote six is the closest that court comes to addressing the concerns of this *amicus*. 574 F.2d at 1161. Its logic, however, is seriously flawed because it flows from a misidentification of the cognate issue. The fundamental issue is not whether there are certain tasks associated with a profession that can be adequately performed by a handicapped person. Rather it is whether or not such a person can be safely and effectively educated and trained as a competent professional. A professional must be capable not only of performing certain tasks when called upon to do so, but also of making the requisite observations and exercising the level of clinical judgment involved in determining which procedures need to be performed, at what time and with what effect.

Because a psychiatrist can practice much of his specialty without resort to invasive procedures, for example, a superficial analysis may lead one to believe that a person with deficient vision could be trained as a psychiatrist with relative ease. This conclusion results from a misconception of a psychiatrist as a theoretically trained psychological counselor. But a psychiatrist is not a psychologist; he is first and foremost a physician practicing a specialized branch of medicine. He must be fully trained as a physician, capable of recognizing and treating pathological states of organic as well as inorganic origin. This kind of training requires a sound grounding in the development of clinical skills which can be achieved only through participation in the series of clerkships in medicine, surgery, pediatrics, obstetrics and gynecology which characterize undergraduate medical education. These clerkships, in turn, require the student to assume, under supervision, gradually increasing professional responsibility for the care of patients whose welfare is the ultimate object of the training. A person who is incapable of safely and effectively participating in such training cannot morally be admitted to a medical education training program.

This is not to say that all vision impairments are disqualifying, but rather that the determination of admissibility must be left to the sound judgment of the medical faculty applying appropriately developed technical standards. Nor does this deny that a technically unqualified handicapped individual might fruitfully participate in some of the courses offered in medical school or effectively perform some tasks associated with medicine. It is only to demonstrate that some handicaps will

inevitably disqualify some persons from the full course of training necessarily required of all physicians.

The Association of American Medical Colleges has commissioned a working group to study the HEW regulations as they relate to medical school admissions and to develop guidelines to assist schools who wish to develop their own technical standards. The report of this group has been distributed to each member school. Appendix A. *Amicus* believes that this is a promising approach which is fair to applicants, permits compliance with the statute, the intent of Congress, and the HEW regulations. Most importantly it permits academic institutions to deal rationally with their dual responsibility to their students and their patients. It precludes the unfortunate consequences which would flow from the decision of the court of appeals—the matriculation of an applicant who would be a hazard to the very patients he was being trained to assist.

CONCLUSION

For the foregoing reasons, the decision of the circuit court should be reversed.

Respectfully submitted,

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APPENDIX

APPENDIX A

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Memorandum #79-4 January 25, 1979

To: Members of the Assembly

FROM: John A. D. Cooper, M.D., President

SUBJECT: Report of the Special Advisory Panel on Technical Standards for Medical School Admission

In March 1978 the Executive Council appointed a Special Advisory Panel on Technical Standards for Medical School Admission and asked the members to review the Department of Health, Education and Welfare regulations relating to Section 504 of the 1973 Vocational Rehabilitation Act, as amended. That statute established a broad governmental policy forbidding discrimination against the handicapped in any program receiving federal financial assistance. The Panel was charged with recommending for institutional consideration guidelines for the development of technical (nonacademic) standards for use in the medical school admissions process. The attached report was approved for transmittal to all medical schools at the January 18, 1979 Executive Council meeting.

It is the Association's hope that this report will serve as a guide to each school in developing technical standards consistent with its own education, research and service objectives. The report is not an official AAMC policy statement, but only an aid to schools seeking assistance in the development of such standards. Its uniform adoption by all medical schools is not expected; the Association is confident that the technical standards developed by individual medical schools will reflect not only the diversity of such institutions, but their commitment that qualified handicapped applicants be admitted.

You will note that the report cautions that these guidelines have not been reviewed by HEW for compliance with their regulations and, therefore, no guarantee can be made that adherence to these standards will protect schools from challenge by disappointed applicants. Rather, the report reflects the conclusion of the Panel and the Executive Council that there are certain minimum standards for physicians that must be examined and enforced in the admissions process.

Any further questions on the Section 504 regulations or this report can be referred to Kat Dolan in my office (202-466-5173).

Attachment

Report of the AAMC Special Advisory Panel on Technical Standards for Medical School Admission

Introduction

In the Rehabilitation Act of 1973, as amended, Section 504 specifies that "no otherwise qualified handicapped individual . . . shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving Federal financial assistance." The Department of Health, Education and Welfare issued regulations implementing the legislation in May 1977 (see Appendix A). The Association of American Medical Colleges has expressed its concern over the impact of these regulations on medical education and admissions policies. In response to the request of many schools, the Executive Council of the Association established a Special Advisory Panel on Technical Standards for Medical School Admission to review the regulations, to assess their impact on medical schools, and to advise schools on compliance with the regulations. The Panel has met three times and has discussed the regulations with a representative of HEW's Office of Civil Rights.

The Panel has joined the Association in condemning the denial without cause of medical school admission to handicapped individuals. The report of the Panel describes medical education and delineates guidelines for minimum technical standards for the Doctor of Medicine degree. Individual schools may wish to use the report to develop technical standards for admission and performance expectations for graduation. Schools should be cautioned, however, that the Panel has not asked HEW to review these guidelines for compliance with Section 504, and cannot guarantee that adherence to them will protect schools from challenge. Rather, these guidelines reflect the Panel's conclusion that there are certain minimum technical standards for physicians which must be examined and enforced in the admissions process.

The Panel has included background material that is familiar to all medical school faculty and administrators to assist interested persons outside of the medical profession in their understanding of the special problems faced by medical schools in their efforts to comply with this law and the accompanying regulations.

Medical Education

The education of a physician encompasses the following components: a preparatory phase in college; a rigorous professional education leading to the M.D. degree; postgraduate or residency training; and "lifelong" continuing education after the conclusion of formal training. Unlike most other professions, medicine awards its degree midway through the educational process and the degree certifies that the individual has acquired a broad base of knowledge and skills requisite for the practice of medicine. It must be emphasized that good patient care requires that the medical education process prepare an individual to be a physician, not a surgeon, a psychiatrist or any other specialist. A broad medical education is, therefore, prerequisite for

entry into specialized postgraduate training programs which in turn require a common body of knowledge, skills, and behaviors. Certain specialties such as psychiatry even include broad general medicine experiences as part of their graduate training program, supporting the final analysis that a good specialist must be first a good physician.

Medical education requires that the accumulation of scientific knowledge be accompanied by the simultaneous acquisition of skills and professional attitudes and behavior. It is in the care of patients that the physician learns the application of scientific knowledge and skills. It is impossible to consider changes in medical education without considering their impact on patients who are an integral part of the educational process. Faculties of medicine have immediate responsibilities to students and patients and ultimate responsibilities to society to graduate the best possible physicians. Admissions standards for medical school must be rigorous and exacting and admissions must be extended only to those who are best qualified to meet the performance standards of medical schools.

The Accreditation Process, Medical School Curricula and the Admission of Students

There are 124 medical schools in the United States accredited by the Liaison Committee on Medical Education, an agency established in 1942 by the Association of American Medical Colleges and the American Medical Association, to assume accreditation responsibilities previously undertaken separately by these organizations. The accreditation of medical schools by this agency assures the public that a school has met national educational standards, that its graduates have completed a rigorous education and achieved the levels of competency necessary for the awarding of the Doctor of Medicine degree, and that the welfare of the patient is protected by compliance with professional norms. Additionally, the accreditation process provides assurance

to state licensing bodies that a candidate for licensure has received a nationally approved education in medicine. State agencies in turn accept the educational qualifications of a candidate for licensure if he has graduated from a medical school accredited by the LCME.

In defining a medical school curriculum, faculties are obligated to adhere to the guidelines provided by the LCME in "Functions and Structure of a Medical School." The educational program leading to the M.D. degree is described therein as follows:

> "The need of every medical student to acquire a foundation of knowledge in the biomedical sciences is self-evident. It is also evident that this foundation necessitates learning objectives related not only to a knowledge of biomedical sciences which are a prerequisite for the study of clinical medicine, but must encompass those fundamentals which will serve as a basis for life-long learning of a constantly changing and expanding body of knowledge.
>
> The foundation of knowledge in the biomedical sciences should include, but not necessarily be limited to, all of the major disciplines of the biological and behavioral sciences. Biochemistry, Pharmacology, Physiology, Anatomy, Pathology and Microbiology are the traditional generic fields of the biomedical sciences, which, along with appropriate elements of the behavioral sciences, are usually considered essential for the education of the physician. These should be taught in sufficient depth and breadth to insure that there is a fundamental knowledge for ongoing continuing medical education.
>
> The study of clinical medicine can best be accomplished with an emphasis on the problems of patients. It is a responsibility of the faculty to insure that each student is provided with an opportunity to observe and

to participate in the expert care of patients with a broad spectrum of disease in each of the major disciplines of medicine. In addition to the traditional clerkships in medicine, pediatrics, surgery, obstetrics and gynecology, and psychiatry, many institutions offer interdisciplinary clerkships and/or clerkships in family medicine. The continued competence of the physician in future years will require that every student utilize the fundamentals of both biomedical and clinical knowledge to evaluate and understand current literature so that as physicians they will understand advances in biomedical sciences and their applications to clinical medicine.

The clinical phase of the curriculum should provide an opportunity for the study of both mental and physical disease, as well as preventive medicine, and the socioeconomic aspects of health and disease, in both well and sick persons and groups. This instruction should relate both to hospitalized and to ambulatory patients. The objectives of the clinical phase of medical education should be described for each of the major disciplines, insuring that there is achievement of comprehensive knowledge in each of these disciplines."

Writing more broadly, the LCME adds further guidelines for a medical curriculum:

"Each student should acquire a foundation of knowledge in the basic sciences that will permit the pursuit of any of the several careers that medicine offers. The student should be comfortably familiar with the methods and skills utilized in the practice of clinical medicine. Instruction should be sufficiently comprehensive so as to include the study of both mental and physical disease in patients who are hospitalized as well as ambulatory. At the same time, it should foster and encourage the development of the specific and unique

interests of each student by tailoring the program in accordance with the student's preparation, competence, and interests by providing elective time whenever it can be included in the curriculum for this purpose.

Attention should also be given to preventive medicine and public health, and to the social and economic aspects of the systems for delivering medical services. Instruction should stress the physician's concern with the total health and circumstances of patients and not just their diseases. Throughout, the student should be encouraged to develop those basic intellectual attitudes, ethical and moral principles that are essential if the physician is to gain and maintain the trust of patients and colleagues, and the support of the community in which the physician lives."

Using the above as guidelines, the faculty of a medical school has the freedom and ultimate responsibility for the design, implementation and evaluation of the medical school curriculum. Such autonomy on the part of a university in matters relating to the curriculum as well as in the selection of faculty and students has long been recognized by the judicial system. This freedom permits innovation and experimentation in the learning resources used, the methods of instruction and the format of the curriculum. Whether traditional or innovative, the curriculum designed by a medical school faculty must ultimately be best suited to the resources of the school, must be in consonance with an institution's education, research and patient care objectives, and must meet LCME requirements.

The faculty of a medical school also bears the responsibility for evaluating student performance and insuring that each student who receives the M.D. degree has fulfilled all requirements of the curriculum. The evaluation of students and the curriculum are both critically reviewed during the accrediting process. If either are found to be deficient, the school's accreditation may be in jeopardy.

In the admission of students, medical school faculty are guided by the LCME which has stated in the "Functions and Structure of a Medical School" that admission decisions should be based not only on satisfactory prior scholastic achievement, but also upon considerations of "personal and emotional characteristics, motivation, industry, resourcefulness and personal health." The LCME will countenance no discrimination on the basis of sex, creed, race or national origin and mandates that students "possess the intelligence, integrity, and personal and emotional characteristics appropriate to the effective physician."

Faculties have placed strong emphasis on the academic achievements of applicants in the sciences relevant to medicine and they have sought evidence of breadth of education. Cognizant of their responsibilities to patients who will be a part of the educational process and to future patients who will entrust their welfare and their lives to graduates, faculties have examined with care the character, personal qualities, motivation, physical health and emotional stability of applicants. Admission has been offered to those who present the highest qualifications for the study and practice of medicine.

Fulfillment of the Requirements for the M.D. Degree

Because the M.D. degree signifies that the holder is a physician prepared for entry into the practice of medicine within postgraduate training programs, it follows that graduates must have the knowledge and skills to function in a broad variety of clinical situations and to render a wide spectrum of patient care.

Candidates for the M.D. degree must have somatic sensation and the functional use of the senses of vision and hearing. Candidates' diagnostic skills will also be lessened without the functional use of the senses of equilibrium, smell and taste. Additionally, they must have sufficient exteroceptive sense (touch, pain and temperature), sufficient proprioceptive sense (position, pressure, movement, stereognosis and vibratory) and sufficient motor function to permit them to carry out the activities described in the sections that follow. They must be able consistently, quickly, and accurately to integrate all information received by whatever sense(s) employed, and they must have the intellectual ability to learn, integrate, analyze and synthesize data.

A candidate for the M.D. degree must have abilities and skills of five varieties including observation; communication; motor; conceptual, integrative and quantitative; and behavioral and social. Technological compensation can be made for some handicaps in certain of these areas but a candidate should be able to perform in a reasonably independent manner. The use of a trained intermediary means that a candidate's judgment must be mediated by someone else's power of selection and observation.

I. *Observation:* The candidate must be able to observe demonstrations and experiments in the basic sciences, including but not limited to physiologic and pharmacologic demonstrations in animals, microbiologic cultures, and microscopic studies of microorganisms and tissues in normal and pathologic states. A candidate must be able to observe a patient accurately at a distance and close at hand. Observation necessitates the functional use of the sense of vision and somatic sensation. It is enhanced by the functional use of the sense of smell.

II. *Communication:* A candidate should be able to speak, to hear and to observe patients in order to elicit information, describe changes in mood, activity and posture, and perceive nonverbal communications. A candidate must be able to communicate effectively and sensitively with patients. Communication includes not only speech but reading and writing. The candidate must be able to communicate effectively and efficiently

in oral and written form with all members of the health care team.

III. *Motor:* Candidates should have sufficient motor function to elicit information from patients by palpation, auscultation, percussion, and other diagnostic maneuvers. A candidate should be able to do basic laboratory tests (urinalysis, CBC, etc.), carry out diagnostic procedures (proctoscopy, paracentesis, etc.) and read EKGs and x-rays. A candidate should be able to execute motor movements reasonably required to provide general care and emergency treatment to patients. Examples of emergency treatment reasonably required of physicians are cardiopulmonary resuscitation, the administration of intravenous medication, the application of pressure to stop bleeding, the opening of obstructed airways, the suturing of simple wounds, and the performance of simple obstetrical maneuvers. Such actions require coordination of both gross and fine muscular movements, equilibrium and functional use of the senses of touch and vision.

IV. *Intellectual-Conceptual, Integrative and Quantitative Abilities:* These abilities include measurement, calculation, reasoning, analysis, and synthesis. Problem solving, *the* critical skill demanded of physicians, requires all of these intellectual abilities. In addition, the candidate should be able to comprehend three dimensional relationships and to understand the spatial relationships of structures.

V. *Behavioral and Social Attributes:* A candidate must possess the emotional health required for full utilization of his intellectual abilities, the exercise of good judgment, the prompt completion of all responsibilities attendant to the diagnosis and care of patients, and the development of mature, sensitive and effective relationships with patients. Candidates must be able to tolerate physically taxing workloads and to function

effectively under stress. They must be able to adapt to changing environments, to display flexibility and to learn to function in the face of uncertainties inherent in the clinical problems of many patients. Compassion, integrity, concern for others, interpersonal skills, interest and motivation are all personal qualities that should be assessed during the admissions and education processes.

Compliance with Section 504

Medical schools are encouraged to look beyond the stereotypes of handicapped individuals and to develop innovative and creative ways of opening the medical school curriculum to competitive, qualified handicapped individuals. Schools have already exhibited flexibility in adapting to the special needs of the educationally disadvantaged and the Association believes that accommodations for some handicaps can occur. Schools are cautioned that the integrity of the curriculum must be maintained and that those elements deemed essential to the education of a physician must be preserved. Since the treatment of patients is an essential part of the educational program, schools must at all costs act to protect the health and safety of patients.

Individual schools are encouraged to use this report to develop technical standards for use in the admissions process. It is inevitable that adherence to minimum requirements will disqualify some applicants including some who are handicapped. This does not imply, however, that a school has discriminated against these applicants. Since discrimination requires drawing a distinction without sufficient justification it follows that making discriminatory judgments on justified grounds is acceptable.

The Association believes that it is not only reasonable but essential for good patient care to require minimum standards for the education of physicians. In assessing applicants for admission it is appropriate for schools to

consider cumulative and progressive disability, as well as the applicant's current physical and emotional status, and drug-induced impairments that may disturb patients and pose obstacles to the safe application of the student's knowledge and skills.

This report has emphasized that the M.D. degree is a broad, undifferentiated degree which is essential for entry into postgraduate training. In the admissions process a medical school must judge not only the scholastic accomplishments and potential of an applicant but also the physical and emotional capacities of the applicant to meet the full requirements of the school's curriculum and to graduate as a skilled and effective practitioner of medicine.

The Panel considered including a list of disease states and handicaps that could compromise the essential abilities and skills that each physician must have. However, the members concluded that a comprehensive list would be encyclopedic and hence, always incomplete. Therefore, the Panel decided to provide (Appendix B) a number of questions related to the outlined above guidelines that might be considered and evaluated in the admissions process. A review of the curricular requirements for accreditation and of the skills described herein should enable medical schools to determine their own technical standards.

Conclusions

The Panel made an extensive review of medical education that went far beyond the essential information contained in this report. As a result, the Panel urges medical school faculties to engage in similar reviews in the development of their technical standards. Compliance with the law, while preserving the required curriculum and protecting the welfare of the patients, demands technical standards that are well reasoned and fully justified. In conclusion, the Panel affirms that:

—The medical education process, which focuses so largely on patients differs markedly from postsecondary education in fields outside the health sciences.

—The primary responsibility for the selection of students and for the content of the curriculum rests with the medical school and its faculty.

—The M.D. degree is, and must remain, a broad, undifferentiated degree attesting to the acquisition of general knowledge in all fields of medicine and the basic skills requisite for the practice of medicine.

—The guidelines for the admission of students and for the education of students as set forth by the Liaison Committee on Medical Education must continue to govern the decisions of medical school faculties.

—All students of medicine must possess those intellectual, ethical, physical and emotional capabilities required to undertake the full curriculum and to achieve the levels of competence required by the faculty.

—Although certain handicaps or combinations of handicaps will prevent some candidates from meeting these minimum technical standards, individual schools should take all necessary steps to prevent unjustified discrimination against the handicapped.

Appendix A

Section 504 of the Rehabilitation Act of 1973, as amended:

> No otherwise qualified handicapped individual in the United States, as defined in Section 7(6), shall, solely by reason of his handicap be excluded from participation in, be denied the benefits of, or be subject to discrimination under any program or activity receiving federal financial assistance.

Following are definitions from the regulation implementing Section 504. The complete regulation and an analysis prepared by the Department of Health, Education and Welfare appeared in the May 4, 1977 *Federal Register* (Vol. 42, No. 86, pages 22676-22701).

> *Handicapped person:* any person who (i) has a physical or mental impairment which substantially limits one or more major life activities, (ii) has a record of such an impairment, or (iii) is regarded as having such an impairment.
>
> *Physical or mental impairment:* (A) any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: neurological; musculoskeletal; special sense organs; respiratory, including speech organs; cardiovascular; reproductive; digestive; genito-urinary; hemic and lymphatic; skin; and endocrine; or (B) any mental or psychological disorder, such as mental retardation, organic brain syndrome, emotional or mental illness, and specific learning disabilities.*
>
> *Qualified handicapped person:* With respect to post-secondary and vocational education services, a handicapped person who meets the academic and technical

* A ruling by the Attorney General has included addiction to alcohol and narcotics as a handicap for the purpose of this statute.

> standards requisite to admission or participation in the recipient's education program or activity.
>
> *Technical standards:* not defined in the regulation. The accompanying analysis states: The term "technical standards" refers to all nonacademic admissions criteria that are essential to participation in the program in question.

Appendix B

This appendix provides sample questions illustrating how medical schools might use these general guidelines to assess individual candidates for admission. In effect, the application of these general guidelines in admissions decisions creates nonacademic or technical standards. To be nondiscriminatory such standards must be considered in all admissions decisions.

This list is not meant to be all-inclusive but rather to serve as a guide to each medical school in developing nonacademic standards consonant with its own objectives in patient care, education, and research. The questions are designed not to disqualify candidates, but to give an admissions committee more complete information about a candidate's ability to meet the school's standards.

1. Is the candidate able to observe demonstrations and experiments in the basic sciences?

2. Is the candidate able to analyze, synthesize, solve problems, and reach diagnostic and therapeutic judgments?

3. Does the candidate have sufficient use of the senses of vision and hearing and the somatic sensation necessary to perform a physical examination? Can the candidate perform palpation, auscultation, and percussion?

4. Can the candidate reasonably be expected to relate to patients and establish sensitive, professional relationships with patients?

5. Can the candidate reasonably be expected to communicate the results of the examination to the patient and to his colleagues with accuracy, clarity and efficiency?

6. Can the candidate reasonably be expected to learn and perform routine laboratory tests and diagnostic procedures?

7. Can the candidate reasonably be expected to display good judgment in the assessment and treatment of patients?

8. Can the candidate reasonably be expected to perform with precise, quick and appropriate actions in emergency situations?

9. Can the candidate reasonably be expected to accept criticism and respond by appropriate modification of behavior?

10. Can the candidate reasonably be expected to possess the perserverance, diligence, and consistency to complete the medical school curriculum and enter the independent practice of medicine?

Panel On Technical Standards For Medical School Admission

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